1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16822 16816

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Elkton R.D.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton R.D. 07/
d. STREET ADDRESS: (Fair Hill)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Alvira — Last: Ayers

4. DATE OF DEATH: Month: December — Day: 8, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: July 23, 1880

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Wesley Ayers

14. MOTHER'S MAIDEN NAME: Mary Rebecca Jamison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Arbie Ritchie, Elkton, Md. Address R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

443x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic myocarditis — 5 yrs.
DUE TO (c): Hypertension & Cerebral Embolism — 4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1966, 19—, to Dec 8—, 19 67 that (I) (we) last saw the deceased alive on Dec 6 1967, and that death occurred at 6:13 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Jacob J. Greenwald M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/9/67

22c. PHYSICIAN'S NAME (Type): Dr. Jacob J. Greenwald, M.D.

22d. ADDRESS: 202 East Main Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/11/67

23c. NAME OF CEMETERY OR CREMATORY: Sharps Cemetery

23d. LOCATION (City, town or county) (State): Fair Hill, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ralph E. Hicks
Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: DEC 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M S-63

1

16823

16817

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 539 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47-3
d. STREET ADDRESS: 904 3rd St., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence — Middle: NMI — Last: Berry

4. DATE OF DEATH: Month 12 — Day 7 — Year 1967

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 9-10-95
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stable hand
10b. KIND OF BUSINESS OR INDUSTRY: --------
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hugh Berry (D)
14. MOTHER'S MAIDEN NAME: Frances Smith (D.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 215 56 56 53
17. INFORMANT — Address: Hospital Records, VAH Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral, aspiration type
4400
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Heart Disease
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6-16, 1966 to 12-7, 1967, XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX and that death occurred at 2:30 AM from causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-8-67
22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.
22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify):
23b. DATE THEREOF: 12-13-67
23c. NAME OF CEMETERY OR CREMATORY: Harmony Mem Park
23d. LOCATION (City or Town) (County) (State): Md.

24. FUNERAL DIRECTOR: Morris A Carter — ADDRESS: 505 H St NW
25a. REC'D BY REGISTRAR DATE: DEC 18 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 20 Film 396 1-15-68

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16824

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16818

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton R.D. 5
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS: Blue Ball Rd. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Roger	Allen	Brooks	December	25,	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		Mar. 1, 1948	19 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machine Tender	Elk Paper Co.	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Walter Zee Brooks	Ella Irene Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	217-50-0223	Walter Z. Brooks, Elkton, Md. R.D. 5

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carbon monoxide intoxication — INTERVAL BETWEEN ONSET AND DEATH: 7 hours

DUE TO

(b)

DUE TO

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
	Found in panel truck with companion. Brooks apparently dead; friend comatose. Ignition on, gas tank empty, engine not running.			
20c. TIME OF INJURY Month, Day, Year (Hour o.m.)	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
Found approx. 6 A.M. 12-25-67		Dogwood Rd. residence	Elkton	Cecil Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑ Inquiry ☑ and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Tillman D. Johnsen M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county): 173 Singerly Ave Elkton

22. DATE SIGNED: 12-27-67

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12/28/67	Elkton Cemetery	Elkton, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	DATE JAN 4 1968	J. Charles Judge

VR A15ME (5)
6M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16825 16819

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 HR
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Massachusetts — b. COUNTY: ESSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Port
d. STREET ADDRESS: Eden Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HARRIET — Middle P. — Last BURBEE
4. DATE OF DEATH: Month December — Day 1 — Year 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: DEC. 12, 1875
9. AGE (In years last birthday) 91 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: MURDOCH McPHERSON
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: GLADYS B. GALE - ROCKPORT, MASS.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple traumatic injuries
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
8161
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Subject, passenger in auto-truck collision
20c. TIME OF INJURY Month, Day, Yeor Hour o.m.: ? p.m. 12 1 19 67
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
20f. (City or town) Elkton (County) Cecil (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Noturol couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Edward F. Wilson, M.D.
Address (Street, city, town, or county):
22. DATE SIGNED: December 2, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-5-67
23c. NAME OF CEMETERY OR CREMATORY: BONDVILLE CEM.
23d. LOCATION (City or Town) (County) (State): BONDVILLE, VERMONT

24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME, Donald T. Pippin
ADDRESS: ELKTON, Md.
25a. REC'D BY REGISTRAR DATE: DEC 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16826

CERTIFICATE OF DEATH

16820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): NORTH EAST
c. LENGTH OF STAY IN 1b: 8 1/2 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address): Pratt Home

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: MD
b. COUNTY: Cecil Harf.
c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn): NORTH EAST Havre de Grace 12.2
d. STREET ADDRESS: 654 Congress Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARABELLA Middle PARKER Last CAMPBELL

4. DATE OF DEATH: Month DEC Day 11 Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 2, 1866

9. AGE (In years last birthday): 101 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of wark dane during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or foreign country): DELTA, PENN.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ISAC PARKER

14. MOTHER'S MAIDEN NAME: SARAH JANE WILEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown): ___ (If yes give war or dates of service): ___

16. SOCIAL SECURITY NO.: ___

17. INFORMANT: Mr. JAMES W. CAMPBELL Address: 40 LAKEVIEW, DRIVE MOORESTOWN, N.J. 08057

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Senile cardiovascular disease
DUE TO
(b): ___
DUE TO
(c): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4221
INTERVAL BETWEEN ONSET AND DEATH: ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I ar Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 ___

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)

20f. (City or tawn) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 12-7, 1962, ta 12-11, 1967, that (I) (we) last saw the deceased alive an 12-1 19 67, and that death occurred at 9:40 P.M. fram causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-11-67

22c. PHYSICIAN'S NAME (Type): ___

22d. ADDRESS: ___

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: DEC. 14 1967

23c. NAME OF CEMETERY OR CREMATORY: SLATEVILLE PRES. CH. YARD

23d. LOCATION (City or Town) (County) (State): DELTA PA.

24. FUNERAL DIRECTOR: R. Madison Mitchell ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: DEC 18 1967

25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16827 16821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Childs
   d. STREET ADDRESS: Maryland
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wilbur; Middle: Carter; Last: Campbell

4. DATE OF DEATH: Month: December; Day: 18; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 27, 1883

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired (paper Mfg)

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mfg.

11. BIRTHPLACE (County & State, or foreign country): Childs, Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John A. Campbell

14. MOTHER'S MAIDEN NAME: Mary Anna Gallaher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: (daughter) Mrs. A. Elizabeth Coyle, Childs, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 4341 - Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Late

DUE TO (b): Pneumonia — 1 wk

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1963, 19..., to Dec 18, 1967, that (I) (we) last saw the deceased alive on Dec 18, 1967, and that death occurred at ...M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph G. Lanzi M.D.

22b. DATE SIGNED: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ Dec. 18, 1967

22c. PHYSICIAN'S NAME (Type): Joseph G. Lanzi

22d. ADDRESS: Elkton Medical Park, Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 21, 1967

23c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Meth. Cem.

23d. LOCATION (City, town or county) (State): R.D. 3, Elkton, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Reese E. Hicks, Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: JAN 4 1968

25b. REGISTRAR'S SIGNATURE: J. Charles Jagge

VR A1S (1)
20M S-63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16823

CERTIFICATE OF DEATH

16822

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: 8 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): VA Hospital, Perry Point, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 337 Calvert Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALLACE — Middle — Lost CANN

4. DATE OF DEATH: Month December — Doy 12 — Year 19 67

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-30-91
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Chestertown, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Cann (Deceased)
14. MOTHER'S MAIDEN NAME: Mary Lively (Deceased)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 220-01-8024
17. INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation with Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Arteriosclerotic Coronary Heart Disease
DUE TO
(c): Arteriosclerosis, Generalized.
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospitol) attended the deceased from April 12, 1967, to Dec. 12, 1967, ~~saw the deceased alive on~~ ~~19~~ and that death occurred at 8L30AM, from causes and at the date stated above.

22a. SIGNATURE: A. L. Mooney — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-12-67
22c. PHYSICIAN'S NAME (Type): A. L. Mooney, M.D.
22d. ADDRESS: VAH., Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/16/67
23c. NAME OF CEMETERY OR CREMATORY: Janes Cemetery
23d. LOCATION (City or Town) (County) (State): Chestertown, Kent Md.

24. FUNERAL DIRECTOR: Kenneth Walley — ADDRESS: KENNETH WALLEY Funeral Home, Chestertown, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 19 1967
25b. REGISTRAR'S SIGNATURE: Nicholas Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16829

CERTIFICATE OF DEATH

16823

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL FAIR HILL
d. STREET ADDRESS: RD #3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Josephine; Middle: Mackie; Last: Corcoran

4. DATE OF DEATH: Month: Dec; Day: 29; Year: 19 67

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: MARCH 8, 1893
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: RICHARD D. AIKEN
14. MOTHER'S MAIDEN NAME: ELEANOR G. WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 213-38-8289
17. INFORMANT: Address: JOHN T. CORCORAN RD 3 ELKTON, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
4200
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: yrs / mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Coronary occlusion with apical infarct/

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 24 Dec 67 19___, to 29 Dec 67 19___, that (I) (we) last saw the deceased alive on 29 Dec 67 19___, and thot death occurred at 5:15 AM from causes and on the date stated above.

22a. SIGNATURE: Wallace Obenhain
M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 29 Dec 67
22c. PHYSICIAN'S NAME (Type): Wallace Obehsian
22d. ADDRESS: Cecilton Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: JAN. 1, 1968
23c. NAME OF CEMETERY OR CREMATORY: SHARPS CEMETERY
23d. LOCATION (City or Town) (County) (State): FAIR HILL CECIL Md.

24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME
ADDRESS: ELKTON Md
25a. REC'D BY REGISTRAR DATE: JAN 5 1968
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16830

CERTIFICATE OF DEATH

16824

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS: 10 Race St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: LILLY M. COSSER

4. DATE OF DEATH: Month / Day / Year: Dec. 13 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 21, 1873

9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Ohio County W.Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Bowman

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 213-26-1298 D

17. INFORMANT: David G. Cosser — Address: Box 695 B, Balt. Md. 21219

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b): Hypertensive Cardiovascular Renal Disease — 12 yrs
DUE TO (c): Generalized arteriolar sclerosis — 12yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1955, to 13 Dec, 1967, that (I) (we) last saw the deceased alive on 13 Oct 1967, and that death occurred at 11:20 A.M., from causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/13/67

22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER MD

22d. ADDRESS: NORTH EAST Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-16-67

23c. NAME OF CEMETERY OR CREMATORY: West Nottingham Presby.

23d. LOCATION (City or Town) (County) (State): Colora Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — ADDRESS: Box 22, North East, Md. — Paul R. Crouch

25a. REC'D BY REGISTRAR DATE: DEC 15 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16831

CERTIFICATE OF DEATH

16825

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Elkton
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Union Hospital Of Cecil County

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Ceder Hill
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Josephine — Middle: E — Lost: Cox

4. DATE OF DEATH: Month: 12 — Doy: 24 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6/1/97

9. AGE (In years last birthday): 70 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & Stote, or foreign country): Cecil, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herbert Wesley(Stepfather)

14. MOTHER'S MAIDEN NAME: Gertrude Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Ella Coverdale (Daughter) — Address: Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cerebral Accident — INTERVAL BETWEEN ONSET AND DEATH: 1-Month
   260X
   Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause last.
   DUE TO (b): Diabetes, Cardiac — 5-Years
   DUE TO (c): Nephritis — 5-Years

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 1/20/ , 1967, to 12/24 , 19 67 that (I) (we) last saw the deceased alive on 12/24/ 1967, and that death occurred at 7:00 A.M., from causes and on the date stated above.

22a. SIGNATURE: James L. Johnson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/26/67

22c. PHYSICIAN'S NAME (Type) James L. Johnson

22d. ADDRESS: 245 East High St., Elkton, Cecil, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/28/67

23c. NAME OF CEMETERY OR CREMATORY: Griffin Cem.

23d. LOCATION (City or Town) (County) (Stote): Ceder Hill, Md.

24. FUNERAL DIRECTOR: Eclark Bell — ADDRESS: 909 Poplar St.

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16832

CERTIFICATE OF DEATH

16826

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 1 hr. 55 min
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
   d. STREET ADDRESS: 127 S. Main St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stephen — Middle: Paul — Last: Crouch

4. DATE OF DEATH: Month: Dec. — Day: 9 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 9, 1967

9. AGE (In years last birthday): ____ yrs. — IF UNDER 1 YEAR: Months: ____ Days: ____ — IF UNDER 24 HRS.: Hours: >1 Min.: 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Cecil Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Paul R. Crouch

14. MOTHER'S MAIDEN NAME: Jeannette Albanese

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Paul R. Crouch — Address: Box 22 North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Immature fetal birth — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Premature uterine expulsion.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 12-11, 19 67 to 12-11, 19 67 that I (we) last saw the deceased alive on 12-11 19 67, and that death occurred at 8:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Jay S. Barnhart Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-11-67

22c. PHYSICIAN'S NAME (Type): Jay S. Barnhart Jr.

22d. ADDRESS: 4 Mauldin Ave. North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-11-67

23c. NAME OF CEMETERY OR CREMATORY: Elkton Cemetery

23d. LOCATION (City, town or county) (State): Elkton Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — ADDRESS: Box 22 North East, Md.

25a. REC'D BY REGISTRAR DATE: DEC 13 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

Cecil

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16833

CERTIFICATE OF DEATH

16827

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Earleville 071
d. STREET ADDRESS: R.F.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: B. — Last: DeHaven

4. DATE OF DEATH: Month: Dec. — Day: 16, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cau.

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: June 6, 1872

9. AGE (In years last birthday): 95 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & State, or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph L. DeHaven

14. MOTHER'S MAIDEN NAME: Ella Page

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Vera L. Hunter, Earleville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
332 X
DUE TO
(b): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Spontaneous Hypoglycemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__, to ____, 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 18 Dec 67

22c. PHYSICIAN'S NAME (Type): Dr. Wallace Obenshain

22d. ADDRESS: Cecilton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-20-67

23c. NAME OF CEMETERY OR CREMATORY: Lawn Croft Cemetery

23d. LOCATION (City or Town) (County) (State): Linwood, Delaware, Pa.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son — ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: DEC 20 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

16834

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16828

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, North East
c. LENGTH OF STAY IN 1b: 85 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): R.D. 1

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, North East
d. STREET ADDRESS: R.D. 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or pnnt): First JOHN — Middle WILLIAM — Last GAMBLE

4. DATE OF DEATH: Month Dec. — Doy 4 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: July 29, 1882

9. AGE (In yeors last birthday): 85 yrs.

IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & Stote, or foreign country): Cecil Co. Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William R. Gamble

14. MOTHER'S MAIDEN NAME: Lavinia A. Benjamin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 218-18-0836A

17. INFORMANT: Miss Etta E. Gamble — Address: R.D. 1 Box 85, North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
4200
DUE TO
Conditions, if ony, which gave rise to immediate couse (o), stoting the underlying couse lost.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from 20 Dec, 1957 to 12/4, 1967, that (I) (we) last saw the deceased alive an 12/4 1967, and that death accurred at 2:15 P.M, from causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 12/4/67

22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER M.D.

22d. ADDRESS: North East, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-7-67

23c. NAME OF CEMETERY OR CREMATORY: Bay View Methodist

23d. LOCATION (City or Town) (County) (State): Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — Paul R. Crouch — ADDRESS: Box 22, North East, Md.

25a. REC'D BY REGISTRAR DATE: DEC 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16835

CERTIFICATE OF DEATH

16829

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Devine Haven Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   d. STREET ADDRESS: 07-1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Elizabeth — Middle: S. — Last: Gatchell

4. **DATE OF DEATH**: Month: December — Day: 16, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 14, 1868

9. AGE (In years last birthday): 99 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10b. KIND OF BUSINESS OR INDUSTRY: Sewing

11. BIRTHPLACE (County & State, or foreign country): Cecil County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Gatchell

14. MOTHER'S MAIDEN NAME: Phoebe Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Claire Cottini, Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Years

4200

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from June, 19 64 to 12-16-, 19 67, that (I) (~~we~~) last saw the deceased alive on 12-14 19 67, and that death occurred at 8:00 A M, from the causes and on the date stated above.

22a. SIGNATURE: Tillman D. Johnson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/16/67

22c. PHYSICIAN'S NAME (Type): Tillman D. Johnson, M.D.

22d. ADDRESS: 123 Singerly Ave. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/19/67

23c. NAME OF CEMETERY OR CREMATORY: Sharps Cemetery

23d. LOCATION (City, town or county) (State): Fair Hill, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Ralph E. Hicks
Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR — DATE: DEC 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16836

CERTIFICATE OF DEATH

16830

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): 1144 Ave. B

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Perry Point
d. STREET ADDRESS: 1144 Ave. B
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Victoria; Middle: ; Lost: Geslock

4. DATE OF DEATH: Month: Dec. Doy: 9, Year: 1967

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Jan 29, 1889

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (County & State, or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No ------

16. SOCIAL SECURITY NO.: 161-03-8763 B

17. INFORMANT Address: Elsa G. Rodriguez, Perry Point, Maryland.

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov, 1964, to Dec 9, 1967, that (I) (we) last saw the deceased alive on Dec 9 1967, and that death occurred at 5:40 A.M., from causes and on the date stated above.

22a. SIGNATURE: H. Rodriguez-Delgado

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-9-67

22c. PHYSICIAN'S NAME (Type): H. Rodriguez-Delgado M.D.

22d. ADDRESS: Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-12-1967

23c. NAME OF CEMETERY OR CREMATORY: Our Mother of Consolation Cem.

23d. LOCATION (City or Town) (County) (State): Mt. Carmel, Penna.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son

ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: DEC 12 1967

25b. REGISTRAR'S SIGNATURE: [signature]

2 1

16837

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16837

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Rising Sun
   c. LENGTH OF STAY IN 1b: 8 hrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Calvert Manor Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Port Deposit
   d. STREET ADDRESS: R.D #1
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: Virginia — Middle: C. — Last: Green

4. **DATE OF DEATH**: Month: Dec. — Day: 7 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: June 10, 1885

9. AGE (In years last birthday): 82 yrs.
   IF UNDER 1 YEAR: Months / Days
   IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Franklin Co. Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ezekel Nichols

14. MOTHER'S MAIDEN NAME: Isabell Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-12-6633

17. INFORMANT: Robert D Green — Address: Port Deposit Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH
   4201
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (b): ASCVD
   DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic bronchitis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m., 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-6, 19 67, to 12-7, 19 __, that (I) (we) last saw the deceased alive on 12-7 19 67, and that death occurred at 10 P.M. from causes and on the date stated above.

22a. SIGNATURE: J. Bamberger Jr. M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 12-8-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-11-67

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cem.

23d. LOCATION (City or Town) (County) (State): Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — ADDRESS: Box 22 North East Md

25a. REC'D BY REGISTRAR: DATE DEC 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Yingling

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

16836

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16832

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: DELAWARE
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS: 2036 Nottingham Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHRISTOPHER — Middle — Last HANES
4. DATE OF DEATH: Month December — Day 16, — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 15, 1967
9. AGE (In years last birthday) — yrs. IF UNDER 1 YEAR: Months 3, Days — IF UNDER 24 HRS.: Hours —, Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Edna Louise Huss
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -- (If yes give wor or dates of service)
16. SOCIAL SECURITY NO. ---
17. INFORMANT Address: Welfare Board, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial pneumonitis (SDII) — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.
(b)
DUE TO
(c)

525 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Charles S. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):
22. DATE SIGNED: December 17, 1967

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/18/67
23c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Memorial
23d. LOCATION (City or Town) (County) (State): Park, Elkton, Md.
24. FUNERAL DIRECTOR: Ralph E. Hicks
ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a. REC'D BY REGISTRAR DATE: DEC 28 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

2-241238

8 - 1

16839

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16833

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 820 Market Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: LEONARD — Middle: L. — Last: HOPKINS

4. **DATE OF DEATH**: Month: December — Day: 28 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 7/6/99

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Artillery Helper

10b. KIND OF BUSINESS OR INDUSTRY: -----

11. BIRTHPLACE (County & State, or foreign country): Catasauqua, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Hopkins (D)

14. MOTHER'S MAIDEN NAME: Cecelia Shoenberger (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 215-28-5563

17. **INFORMANT** Address: Hospital Records, VAH Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:
4201
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Acute coronary thrombosis — 6 days
DUE TO
(c): Arteriosclerotic heart disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December 22, 67 to Dec. 28, 19 67 that (I) (we) last saw the deceased alive on 12/28/67 19___, and that death occurred at 11:05 a.m. M, from causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12/29/67

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY

22d. ADDRESS: VA Hospital, Perry Point, Maryland

23a. (BURIAL) CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 1/2/68

23c. NAME OF CEMETERY OR CREMATORY: Fairview

23d. LOCATION (City or Town) (County) (State): Catasauqua Pa.

24. FUNERAL DIRECTOR: Pennington & Son — ADDRESS: Havre de Grace Md

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16840

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16834

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton c. LENGTH OF STAY IN 1b: d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East d. STREET ADDRESS: North East, Md. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First CASSEL — Middle James — Last HOWERY	4. DATE OF DEATH: Month December — Day 8 — Year 19 67
5. SEX: Male	6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: August, 1905
9. AGE (In years last birthday): 62 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY: Machine Shop
11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edd Howery	14. MOTHER'S MAIDEN NAME: Claudia Hawley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Mrs. Mable Howery, North East, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH
465 x
DUE TO (b):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Edward F Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

22. DATE SIGNED: December 8, 1967

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

Address (Street, city, town, or county):

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 12/11/67	23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Meth. Cemetery	23d. LOCATION (City or Town) (County) (State): Ebenezer, Cecil, Md.	
24. FUNERAL DIRECTOR — ADDRESS: Ralph E. Hicks, Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR: DATE DEC 14 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15ME (5) 6M 1/67

1

16841 16835

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY: Cecil, MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: New Jersey b. COUNTY: Camden
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point — c. LENGTH OF STAY IN 1b: 135 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camden
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital	d. STREET ADDRESS: 652 S. 3rd Street — e. IS RESIDENCE ON A FARM? YES ☐ NO XX

3. NAME OF DECEASED (Type or print) First: William Middle: M. Last: James — 4. DATE OF DEATH Month: December Day: 17 Year: 1967

5. SEX: Male — 6. COLOR OR RACE: Negro — 7. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: July 18, 1914 — 9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer — 10b. KIND OF BUSINESS OR INDUSTRY: Farm — 11. BIRTHPLACE (County & State, or foreign country): Red Spring, N.Carolina — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Walter James — 14. MOTHER'S MAIDEN NAME: Mildred (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II — 16. SOCIAL SECURITY NO.: 248-12-7265 — 17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

332X

IMMEDIATE CAUSE (a) Pulmonary Congestion and Edema

DUE TO (b) (Stroke) - Infarction of brain — 7-8 Days

DUE TO (c) Cerebral Arteriosclerosis, far advanced.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) XXXXXXXX attended the deceased from August 4, 1967, to December 17, 1967, XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX and that death occurred at 10:30pm from causes and on the date stated above.

22a. SIGNATURE: A. L. Mooney M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. XX — 22b. DATE SIGNED: 12-18-67

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D. — 22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 12-23-67 — 23c. NAME OF CEMETERY OR CREMATORY: New Camden Cemetery — 23d. LOCATION (City or Town) (County) (State): Camden, N. J.

24. FUNERAL DIRECTOR: Lee C. Patterson & Son — ADDRESS: Perryville, Md. — Carl Miller 831 Vanhook St., Camden, N.J. — 25a. REC'D BY REGISTRAR DATE: DEC 20 1967 — 25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16842 16836

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: CECIL — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BAINBRIDGE
   c. LENGTH OF STAY IN 1b: 2 hrs 47 min
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): STATION HOSPITAL, NTC BAIN MD

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Pennsylvania
   b. COUNTY: Chester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nottingham
   d. STREET ADDRESS: RD#1 Box 166
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First JOHN Middle JOSEPH Last JULIANO

4. **DATE OF DEATH**: Month DEC Day 27 Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [XX] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 27 DEC 67

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours 2 Min. 47

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): CECIL COUNTY, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOSEPH JAMES JULIANO

14. MOTHER'S MAIDEN NAME: ELINOR SOLTROFF

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: FATHER Address: RT#1, NOTTINGHAM, PA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): IMMATURITY — INTERVAL BETWEEN ONSET AND DEATH:

776X

DUE TO (b): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1658, 27 DEC 19 67 to 1905, 27 DEC 19 67, that (I) (we) last saw the deceased alive on 1905, 27 DEC 19 67, and that death occurred at 1905, from the causes and on the date stated above.

22a. SIGNATURE: C. Martin Bobrowsky (M) USNR M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: 27 DEC 67

22c. PHYSICIAN'S NAME (Type): LT MARTIN BOBROWSKY MC USNR

22d. ADDRESS: Station Hospital, USNTC, Bainbridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-29-67

23c. NAME OF CEMETERY OR CREMATORY: Cathedral Cemetery

23d. LOCATION (City, town or county) (State): Wilmington, Delaware

24. FUNERAL DIRECTOR'S SIGNATURE: Lee V. Patterson & Son

ADDRESS: LEE V. PATTERSON & SON, PERRYVILLE, Md.

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE

VR A1S (4)
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16843

CERTIFICATE OF DEATH

16837

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: CECIL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
   c. LENGTH OF STAY IN 1b: 1 WEEK
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD — b. COUNTY: CECIL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
   d. STREET ADDRESS: 802 BRIDGE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

07-1

3. NAME OF DECEASED (Type or print): First: MARY — Middle: ELIZABETH — Last: KEITHLEY

4. DATE OF DEATH: Month: 12 — Day: 19 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-13-83

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): ELKTON, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W. HEATH

14. MOTHER'S MAIDEN NAME: MARGARET CROWE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: FRANCES E. CONWAY — Address: 802 BRIDGE, ST. ELKTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: YEARS
   4200
   DUE TO
   (b)
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
   DUE TO
   (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 12-14-, 1967, to 12-19, 1967, that (I) (we) last saw the deceased alive an 12-19-1967, and that death accurred at 4:10 P.M, from causes and an the date stated abave.

22a. SIGNATURE: William D. Johnson — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-20-67

22c. PHYSICIAN'S NAME (Type): Tillman D. Johnson M.D.

22d. ADDRESS: 123 Sinserly Ave., Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12-22-67

23c. NAME OF CEMETERY OR CREMATORY: ELKTON

23d. LOCATION (City or Town) (County) (State): ELKTON CECIL MD.

24. FUNERAL DIRECTOR: Robert Foard — ADDRESS: PIPPIN FUNERAL HOME, ELKTON, MD

25a. REC'D BY REGISTRAR DATE: DEC 26 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16844 16838

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Perry Point, Maryland
c. LENGTH OF STAY IN 1b: 186 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): VA Hospital, Perry Point, Maryland

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Bel Air
d. STREET ADDRESS: 138 Maulsby Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: H. — Lost: King

4. DATE OF DEATH: Month: December — Doy: 25 — Yeor: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 3/28/96

9. AGE (In yeors last birthdoy): 71 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Well Driller

10b. KIND OF BUSINESS OR INDUSTRY: Contractor

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert L. King

14. MOTHER'S MAIDEN NAME: Effie A. Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 229031523

17. INFORMANT Address: Medical Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Bronchopneumonia, bilateral, severe — INTERVAL BETWEEN ONSET AND DEATH: 10 days
1621
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
DUE TO (b): Bronchogenic carcinoma, both lower lobes — 3 to 6 mo.
DUE TO (c): Arteriosclerotic heart disease, severe — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor / Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 22, 1967 to Dec. 25, 1967, that (I) (we) last saw the deceased alive an Dec. 25 1967, and that death accurred at 8:20 P.M. from causes and an the date stated abave.

22o. SIGNATURE: S. GOLDGRABEN — M.D. — ATTENDING PHYS. ☐ — MED. DIRECTOR ☐ — STAFF PHYS. ☒

22b. DATE SIGNED: 12/26/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: VAH, Perry Point, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 12/28/67

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Mem. Gardens

23d. LOCATION (City or Town) (County) (State): Bel Air Md. Harford

24. FUNERAL DIRECTOR ADDRESS: Pennington & Son, Havre de Grace, Md.

25o. REC'D BY REGISTRAR DATE: DEC 28 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

16845

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16839

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 23 yrs, 8 mos & 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): Alexandria 83-3
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jordan — Middle: Whitley — Last: Mayo

4. DATE OF DEATH: Month: December — Day: 24 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 22, 1904

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during mast af warking life, even if retired): Bus Driver

10b. KIND OF BUSINESS OR INDUSTRY: Transportation

11. BIRTHPLACE (County & State, ar foreign country): Greenville, N.Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Allen Mayo

14. MOTHER'S MAIDEN NAME: Lula S. Whitley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn): Yes (If yes give war ar dates of service): 2/28/23-4/18/24

16. SOCIAL SECURITY NO.: 226-26-2263

17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only ane couse per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocordial inforation — INTERVAL BETWEEN ONSET AND DEATH: 15-30 min.
DUE TO (b): Arteriosclerotic heart disease, severe with recent occlusion of right coromary artery — years
DUE TO (c): Pulmonary edema, acute, marked, bilat. — 30-60 min.
Conditians, if any, which gave rise to immediate couse (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture af injury in Port I or Part II af item 18.)

20c. TIME OF INJURY Month, Day, Yeor Haur a.m. p.m.: VA 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)

20f. (City ar tawn) (County) (State)

21. I certify that I XXXXXXXXXX attended the deceased from April 13, 1944, to Dec. 24, 1967, XXXXXXXXXX and that death accurred at 5:20 PM, from causes and an the date stated abave.

22a. SIGNATURE: Joaquin R. Garcia M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-24-67

22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 12-24-67
23c. NAME OF CEMETERY OR CREMATORY: Parkinson
23d. LOCATION (City or Town) (County) (State): Greenville N.C.

24. FUNERAL DIRECTOR: Lessenberry Funeral Home
ADDRESS: Havre de Grace Md

25a. REC'D BY REGISTRAR DATE: DEC 27 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

16846 16846

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cecilton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: J. — Middle: LEROY — Last: McCAULEY

4. DATE OF DEATH: Month: December — Day: 8, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October, 2, 1897

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY: Automobile

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank McCauley

14. MOTHER'S MAIDEN NAME: Anna Laney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 217-03-1289-A

17. INFORMANT: Mrs. Marie M.McCauley, Address: Cecilton, Md.21913

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 10 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypernephroma with metastases to rt femur with fracture

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 6 Sept, 1967, to 8 Dec, 1967, that (I) (we) last saw the deceased alive on 8 Dec 1967, and that death occurred at 6 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 9 Dec 67

22c. PHYSICIAN'S NAME (Type): Wallace Obenshain, M.D.

22d. ADDRESS: Cecilton, Md. 21913

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec.11,1967

23c. NAME OF CEMETERY OR CREMATORY: Galena Cemetery

23d. LOCATION (City, town or county) (State): Galena, Kent, Md.

24. FUNERAL DIRECTOR: Edward Fellows & Son, ADDRESS: Millington, Md.21651

25a. REC'D BY REGISTRAR DATE: DEC 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16847

CERTIFICATE OF DEATH

16841

1. **PLACE OF DEATH**
   a. COUNTY: CECIL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
   c. LENGTH OF STAY IN 1b: 1 DAY
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MD — b. COUNTY: CECIL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESAPEAKE CITY 07-1
   d. STREET ADDRESS: GEORGE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: WILLIAM — Middle: J. — Last: METZ

4. **DATE OF DEATH**: Month: 12 — Day: 28 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 1-4-1883

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: CHES. TOWN

11. BIRTHPLACE (County & State, or foreign country): CHESAPEAKE CITY MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOHN METZ

14. MOTHER'S MAIDEN NAME: MARY MEEKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-10-9768A

17. INFORMANT: BLANCHE W. METZ — Address: CHESAPEAKE CITY, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): CARDIOVASCULAR RENAL DISEASE
   DUE TO
   (b): CHRONIC ARTERIOSCLEROSIS
   DUE TO
   (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   442 X
   INTERVAL BETWEEN ONSET AND DEATH: SEVERAL YEARS / SEVERAL YEARS

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): GENERALIZED ARTERIOSCLEROSIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from JULY 1, 1934 to DEC 28, 67, that (I) (we) last saw the deceased alive on DEC 28 1967 and that death occurred at 11:55 A.M. from causes and on the date stated above.

22a. SIGNATURE: Henry V. Davis M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 12-29-67

22c. PHYSICIAN'S NAME (Type): HENRY V. DAVIS

22d. ADDRESS: CHESAPEAKE CITY, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12-30-67

23c. NAME OF CEMETERY OR CREMATORY: WARWICK

23d. LOCATION (City or Town) (County) (State): WARWICK CECIL MD.

24. FUNERAL DIRECTOR: Robert Tocci — ADDRESS: PIPPIN FUNERAL HOME ELKTON, MD

25a. REC'D BY REGISTRAR DATE: JAN 2 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

A34 4/18/68

16843

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16842

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
AUGUSTUS	BRICE	MOORE, Sr.	December 30, 1967	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	June 20, 1888 (1888)	79 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md.	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Town Pt. Rd Chesapeake City, rural		Ret. Real Estate Adj.	Real Estate

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil.	Rural City Chesapeake	YES ☐ NO ☒	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles		Moore	Frances		Brice

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
	214-32-0535	A. Brice Moore, Jr, Town Point Rd,	Chesapeake City Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pulmonary edema . Coronary insufficiiency.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from Jan 2, 19 67, to 30 Dec, 19 67, that (I) (we) last saw the deceased alive an 29 Dec 19 67, and that in (my) (aur) apinion death accurred an the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Wallace Obenshain			1		2 Jan 67

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Wallace Obenshain, M.D.	Cecilton, Md. 21913

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jan. 2, 1968	St. Pauls Cemetery	Chestertown, Rural, Kent, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Edward Fellows & Son,	Millington, Md. 21651	DATE JAN 4 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

16849 — 16843

1. PLACE OF DEATH
a. COUNTY: Cecil County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 40 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): VA Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Michigan
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eaton Rapids
d. STREET ADDRESS: 626 Water St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dale — Middle: H. — Last: Nicholas

4. DATE OF DEATH: Month: December — Doy: 19 — Year: 67

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-12-85

9. AGE (In yeors last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unk.

10b. KIND OF BUSINESS OR INDUSTRY: Unk.

11. BIRTHPLACE (County & State, or foreign country): Salem, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Silas Nicholas

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes give wor or dotes of service): WW 1

16. SOCIAL SECURITY NO.: 217-54-76-09

17. INFORMANT: VA Hospital Records - Perry Pt., Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Bronchopneumonia, bilat.
4500
DUE TO
(b): Arteriosclerosis, generalized, severe of old age
DUE TO
(c):
Conditions, if any, which gave rise to immediate couse (o), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m.: VA 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-26- , 19 27 , to 12-19 , 19 67, [illegible] 2:30 AM, from causes and an the date stated above.

22a. SIGNATURE: A. L. Mooney
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-19-67

22c. PHYSICIAN'S NAME (Type): A.L.Mooney, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): removal

23b. DATE THEREOF: 12-19-67

23c. NAME OF CEMETERY OR CREMATORY: Unknown

23d. LOCATION (City or Town) (County) (State): Eaton Rapids Mich.

24. FUNERAL DIRECTOR: Pettit Funeral Home
ADDRESS: EatonRapids, Mich.

25a. REC'D BY REGISTRAR DATE: DEC 26 1967

25b. REGISTRAR'S SIGNATURE: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16850

CERTIFICATE OF DEATH

16844

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 36 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Alexandria
d. STREET ADDRESS: 907 2nd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lowell — Middle: Leslie — Lost: Niel Sr.

4. DATE OF DEATH: Month: 12 — Doy: 7 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 11-06-08
9. AGE (In yeors lost birthdoy): 59 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker
10b. KIND OF BUSINESS OR INDUSTRY: ---------
11. BIRTHPLACE (County & Stote, or foreign country): Waterloo, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bert Niel (D)
14. MOTHER'S MAIDEN NAME: Martha Hively

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes give wor or dotes of service): WWII
16. SOCIAL SECURITY NO.: 578 28 11 70
17. INFORMANT Address: Hospital Records, VAH Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive abdominal hemorrhage, acute
1561
DUE TO (b): Ruptured Necrotic Tumor Nodule in liver
Conditions, if ony, which gove rise to immediate cause (o), stoting the underlying couse lost.
DUE TO (c): Carcinoma of liver, with multiple tumor nodules

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-1, 1967, to 12-7, 1967 and that death occurred at 5:15 PM, from causes and on the date stated above.

22o. SIGNATURE: A. L. Mooney — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-8-67
22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.
22d. ADDRESS: VA Hospital, Perry Point, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 12/17/67
23c. NAME OF CEMETERY OR CREMATORY: Cmtp.
23d. LOCATION (City or Town) (County) (State): Valley Nebraska

24. FUNERAL DIRECTOR: Cunningham & Have & Grace Mf
ADDRESS:
25o. REC'D BY REGISTRAR DATE: DEC 13 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Juggs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16851

CERTIFICATE OF DEATH

16845

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PERRY POINT
c. LENGTH OF STAY IN 1b: 279 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): VA Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Penna.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Titusville
d. STREET ADDRESS: Gen Delivery
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

75.3

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
Thomas	G.	O Dell	December	13,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In yeors lost birthday)	IF UNDER 1 YEAR Months / Doys	IF UNDER 24 HRS. Hours / Min.
Male	White		12-8-96	71 yrs.		

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired seaman		Titusville, Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas O'Dell (D)	Caroline (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW I	315-20-89-70	VA Hospital Records - Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
331 X
IMMEDIATE CAUSE (o): Acute cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1½-2 days
DUE TO
(b): Cerebral arteriosclerosis severe w/hypertension — yrs.
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Arteriosclerosis, generalized

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-9-67, 19__ to 12-13-67, 19__, ~~that I (last) saw the deceased alive on~~ ~~19~~, and that death occurred at 2:10 M, from causes and on the date stated above.

22o. SIGNATURE	M.D.	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22b. DATE SIGNED
A. L. Mooney					12-13-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
A. L. MOONEY, M.D.	VA Hospital - Perry Point, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	12-15-67	Baltimore National Cem.	Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
PATTERSON FUNERAL HOME - Perryville, Md.	DEC 20 1967	Charles Jones

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16852

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16846

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ELKTON 07-1
d. STREET ADDRESS: RD #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: OLLIE — Middle: MAY — Last: OFFIELD

4. DATE OF DEATH: Month: DECEMBER — Day: 25 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 30, 1904

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): SULLIVAN Co. TENN.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: I. E. Stone

14. MOTHER'S MAIDEN NAME: Hattie Combs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT: James W. Offield — Address: R.D. 1 Box 356 ELKTON Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Mars
4200
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Tillman D. Johnson M.D.

EXAMINER'S NAME (Type): Tillman D Johnson M.D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Elkton, Md

22. DATE SIGNED: 12/28/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-28-67

23c. NAME OF CEMETERY OR CREMATORY: North East Meth

23d. LOCATION (City or Town) (County) (State): North East Cecil Md

24. FUNERAL DIRECTOR: Grant Funeral Home — ADDRESS: Box 22 North East, Md — Paul A. Grant

25a. REC'D BY REGISTRAR — DATE: DEC 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/66

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16853

CERTIFICATE OF DEATH

16847

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: New Jersey — b. COUNTY: Union
   c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Elizabeth
   d. STREET ADDRESS: 716 Garden Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

67-3

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
STANLEY		PARDO	December	5	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		4-2-93	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Railroad	Poland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
YES WWI	152-01-2571	VA Hospital Records, Perry Pt., Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary congestion and edema
DUE TO (b) Cerebral infarction, massive, lt. side of brain.
DUE TO (c) Cerebral arteriosclerosis, severe
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.
332X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)			
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. VA 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. **I certify** that ~~I (this hospital) attended the deceased from~~ 2-21- , 1967 , to 12-5 , 1967 ~~, I last saw the deceased alive on~~ and that death occurred at 8:10 pM, from causes and on the dote stoted above.

22a. SIGNATURE	ATTENDING PHYS. M.D. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22b. DATE SIGNED
A.L. Mooney				12-6-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
A.L. MOONEY, MD	VA Hospital, Perry Pt., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Removal	12-11-1967	Long Island National Cem.	Long Island, N.Y.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
[illegible]	DEC 12 1967	J. Charles Judge

1

FOR STATE HEALTH DEPT.

16854

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16848

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Northeast
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hance's Point, NorthEast, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Delaware — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS: 421 Orchard Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First GEORGE — Middle PEMBERTON — Last PEMBERTON
4. DATE OF DEATH: Month December — Day 8, — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: JULY 4, 1893
9. AGE (In years lost birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PLUMBER
10b. KIND OF BUSINESS OR INDUSTRY: PLUMBING
11. BIRTHPLACE (State or foreign country): NEWARK, DEL.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: PUSEY PEMBERTON
14. MOTHER'S MAIDEN NAME: CATHERINE CHALMERS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: CATHERINE S. GREGG - NEWARK, DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH
929.8
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.): drowned (was deceased when found)
20c. TIME OF INJURY Month, Day, Year: Hour 10:20 p.m. 12/8/ 19 67
20d. INJURY OCCURRED While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): water
20f. (City or town) (County) (State): Cecil, Maryland

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Werner U. Spitz M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]
Address (Street, city, town, or county):
22. DATE SIGNED: 12/9/67

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: DEC. 12, 1967
23c. NAME OF CEMETERY OR CREMATORY: WHITE CLAY CREEK
23d. LOCATION (City or Town) (County) (State): NEWARK, N.CASTL. DEL.
24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME — ADDRESS: ELKTON, MD
25a. REC'D BY REGISTRAR — DATE: DEC 12 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

16855 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16849

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton Rural
c. LENGTH OF STAY IN 1b: 13 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 5 Box 247 C.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton Rural 07-1
d. STREET ADDRESS: Route 5 Box 247 C.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stephen — Middle: Charles — Last: Ragan, Jr.
4. DATE OF DEATH: Month: december — Day: 26 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/10/1901
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stephen Charles Ragan, Sr.
14. MOTHER'S MAIDEN NAME: Mabel Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 218-03-5059A
17. INFORMANT — Address: Mrs. Kathryn Mathewson, Wilm. Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): GSW, head, self-inflicted — INTERVAL BETWEEN ONSET AND DEATH: Instant
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
976X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Placed muzzle of 12 Ga shotgun against forehead and fired
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.: 12-26 1967 2:30 p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Garage, residence
20f. (City or town) (County) (State): Vic Andora Cecil Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☑, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: T. Millard D. Johnson M.D.
EXAMINER'S NAME (Type): T. Millard D. Johnson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county): 123 Singerly Ave, Elkton

22. DATE SIGNED: 12-26-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/30/67
23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove Cem
23d. LOCATION (City or Town) (County) (State): Peachbottom Pa.

24. FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: JAN 2 1968
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15ME (5)
6M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16856 — 16850

CERTIFICATE OF DEATH

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 7 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Delaware — b. COUNTY: N.C.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
   d. STREET ADDRESS: 334 E.Main Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Frances — Middle: Ruth — Last: Rhoden

4. **DATE OF DEATH**: Month: December — Day: 31 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 12,1913

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Levy

14. MOTHER'S MAIDEN NAME: Rachel Worsky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.: 487-01-9351

17. INFORMANT: Mrs.Mary E.Watt — Address: 4714 Fairmount Kansas City,Mo.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane couse per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	7 days
DUE TO (b)	Coronary arteriosclerosis	8 yrs
DUE TO (c)		

4201

Canditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost.

PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hepatic Cirrhosis Porto-Caval Shunt

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I ar Part II af item 18.)

20c. TIME OF INJURY Manth, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at wark ☐ Not While at wark ☐

20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 1962, 19___, to Dec 31, 1967, that (I) (we) last saw the deceased alive an 12-31 1967, and that death accurred at 7:40 PM, fram causes and an the date stated abave

22a. SIGNATURE: Williford Eppes M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-1-68

22c. PHYSICIAN'S NAME (Type): Williford Eppes

22d. ADDRESS: Newark,Delaware

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1/6/68

23c. NAME OF CEMETERY OR CREMATORY: Mt.Olivet Cem.

23d. LOCATION (City or Town) (County) (State): Kansas City,Mo.

24. FUNERAL DIRECTOR: K.T.Jones — ADDRESS: Newark, Delaware

25a. REC'D BY REGISTRAR DATE: JAN 4 1968

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16857 Item #8 Film #G396 12/20/67 ph

CERTIFICATE OF DEATH

16851

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Pennsylvania — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville c. LENGTH OF STAY IN 1b: 32 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia 75-3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital, Perry Point, Md.	d. STREET ADDRESS: 2232 N. Fairhill St e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Charles	E.	Rost	December	10	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	NEVER MARRIED ☒	1/7/1909 12/10/67	58 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Odd jobs	Pennsylvania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Joseph Rost	Marie Nee Klett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes WORLD WAR II	186 10 6600	VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

350 X

IMMEDIATE CAUSE (a): Acute Pulmonary Edema secondary to aspiration of gastric contents

DUE TO (b): Parkinson's Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Multiple rib fractures incident to fall down steps

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
	From fall down steps

20c. TIME OF INJURY Hour a.m. p.m. / Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
12:40 p.m. 12-6 1967 VA		VA Hospital	Perry Point Cecil Md.

21. **I certify** that (I) (this hospital) attended the deceased from November 8, 1967, to December 10 1967, that (I) (this hospital) last saw the deceased alive on [illegible] 1967, and that death occurred at 7:00 a.m., from causes and on the date stated above.

22a. SIGNATURE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
A. L. Mooney M.D.		12-10-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
A. L. MOONEY, M.D.	VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Dec. 14, 1967	Mt. Moriah Cem.	Philadelphia, Pa.

24. FUNERAL DIRECTOR / ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee A. Patterson & Son Perryville, Md.	DEC 12 1967	Charles Judge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16858

CERTIFICATE OF DEATH

16852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Cecil — Elkton — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton c. LENGTH OF STAY IN 1b: 13 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital Of Cecil County	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Cecil c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town): Charlestown, Maryland 07-1 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Edna — Middle: E — Last: Ruppert	4. DATE OF DEATH: Month: 12 — Day: 30 — Year: 1967
5. SEX: Female	6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 5/7/1899
9. AGE (In years last birthday): 68 yrs.	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Photographer	10b. KIND OF BUSINESS OR INDUSTRY: Portrait
11. BIRTHPLACE (County & State, or foreign country): Agusta County, Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Elijah M. Deadrick	14. MOTHER'S MAIDEN NAME: Nannie Elizabeth Taylor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): No	16. SOCIAL SECURITY NO.: 402-50-4671
17. INFORMANT Address: John Ruppert (Husband) Same	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Coronary with Infarction	1-Day
DUE TO (b)	Heart Condition	7-Years
DUE TO (c)	Diabetes	7-Years

260 X

Conditians, if any, which gave rise to immediate cause (a), stoting the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) this hospital attended the deceased from 12/4/, 1967, to 12/30/, 1967, that (I) (We) last saw the deceased alive an 12/30/ 1967, and that death occurred at 7:30 P.M., from causes and an the date stated above.

22a. SIGNATURE: James L. Johnson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1/2/68

22c. PHYSICIAN'S NAME (Type): James L. Johnson M.D.

22d. ADDRESS: 245 E. High St., Elkton, Cecil, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	1-3-68	North East Methodist	North East Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — ADDRESS: Box 22 North East, Md.

25a. RECD. BY REGISTRAR DATE: JAN 5 1968

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16859

CERTIFICATE OF DEATH

16853

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 18 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   d. STREET ADDRESS: Box 15 R.D. 3
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: George — Middle: F. — Last: Shumate

4. **DATE OF DEATH**: Month: December — Day: 6, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 25, 1919

9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: R.M.R. Corp.

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sam Shumate

14. MOTHER'S MAIDEN NAME: Anna -------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 227-20-9631

17. INFORMANT — Address: Box 15 R.D. 3: Mrs. Mamie B. Shumate, Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Artery Thrombosis
DUE TO
(c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-6-, 1967, to 12-6-, 1967, that (I) (we) last saw the deceased alive on 12-6- 1967, and that death occurred at 4 P. M. from causes and on the date stated above.

22a. SIGNATURE: William D. Johnson — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-7-67

22c. PHYSICIAN'S NAME (Type): Tillman D. Johnson M.D.

22d. ADDRESS: 123 Sinserly Ave, Elkton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/9/67

23c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Meth. Cemetery

23d. LOCATION (City or Town) (County) (State): Cherry Hill, Md.

24. FUNERAL DIRECTOR — ADDRESS: Ralph E. Hicks — Hicks Home for Funerals, Elkton, Md.

25a. REC'D BY REGISTRAR DATE: DEC 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16860 Item #4 Film #G396 12/20/67 ph 16854

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH o. COUNTY: CECIL MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE: Md. b. COUNTY: CECIL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON c. LENGTH OF STAY IN 1b: 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON 07-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): UNION HOSPITAL	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: MARY	Middle: ANN	Last: TAYLOR	4. DATE OF DEATH	Month: Dec.	Day: 8	Year: 1967	
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: DEC. 5, 1967	9. AGE (In years lost birthday): — yrs.	IF UNDER 1 YEAR: Months / Days: 1	IF UNDER 24 HRS.: Hours / Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country): Md.	12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME: WENDELL H. TAYLOR	14. MOTHER'S MAIDEN NAME: FRANCIS L. EDGE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address: FRANCIS L. FRETZ - ELKTON, Md.						

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PREMATURITY
776 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Dec 5, 1967, to Dec 6, 1967, that (I) (we) last saw the deceased alive on Dec 6 1967, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: Robert L Gray M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/8/67

22c. PHYSICIAN'S NAME (Type): ROBERT L. GRAY

22d. ADDRESS: ELKTON, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE THEREOF: DEC. 11, 1967	23c. NAME OF CEMETERY OR CREMATORY: ELKTON CEMETERY	23d. LOCATION (City or Town): ELKTON (County): CECIL (State): Md.	
24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME	ADDRESS: Donald Dee ELKTON Md.	25a. REC'D BY REGISTRAR DATE: DEC 12 1967	25b. REGISTRAR'S SIGNATURE: Charles Yeager	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16861 16855

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 24 YRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Church Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: CECIL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   d. STREET ADDRESS: Union Church Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD — Middle DANIEL — Last WALLS

4. DATE OF DEATH: Month December — Day 10 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-13-31

9. AGE (In years last birthday): 36 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: ELK. PAPER CO

11. BIRTHPLACE (State or foreign country): ELKTON, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DANIEL MERIDETH

14. MOTHER'S MAIDEN NAME: AGNES LOTMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 221-20-6666

17. INFORMANT: AGNES WALLS — Address: RD#1 NEWARK, DEL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shotgun wound of the neck
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
981X

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Subject during argument

20c. TIME OF INJURY Month, Day, Year: Hour 7:30 p.m. 12 10 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Elkton (County) Cecil (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Edward F. Wilson M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): Edward F. Wilson, M.D.

Address (Street, city, town, or county):

22. DATE SIGNED: December 11, 196

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12-14-67

23c. NAME OF CEMETERY OR CREMATORY: ELKTON

23d. LOCATION (City or Town) ELKTON (County) CECIL (State) MD

24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME — ADDRESS: Robert Lead ELKTON, MD.

25a. REC'D BY REGISTRAR DATE: DEC 15 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16862

CERTIFICATE OF DEATH

16856

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point c. LENGTH OF STAY IN 1b: 6 yrs, 5 mo & 11 days	c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Baltimore 032
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA HOSPITAL	d. STREET ADDRESS: 6643 Dalton Drive e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
William	Edward	Warner	December	7	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		July 25, 1897	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Chef	Restaurant	Baltimore, Maryland	U. S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William - Unknown	Minnie - Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes WW II	216-03-5192	VA HOSPITAL RECORDS, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if ony, which gave rise to immediate cause (a), stoting the underlying cause last.
(b): Pulmonary Embolus
DUE TO
(c): Chronic brain syndrome with cerebral arterio/ sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 26, 1961, to Dec. 7, 1967, [illegible] last saw the deceased alive on [illegible], and that death occurred at 1:45 PM, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
		12-7-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
S. GOLDGRABEN, M.D.	VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Dec. 11, 1967	Baltimore National Cem.	Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. B. Fleming — Singleton Funeral Home, Glen Burnie, Maryland	DEC 11 1967	J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16863

CERTIFICATE OF DEATH

16857

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: 2 Mos.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Delaware — b. COUNTY: N.C.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark — 46-3
   d. STREET ADDRESS: 111 Manns Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Florence — Middle: H. — Last: White

4. **DATE OF DEATH**: Month: December — Day: 15 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): 72 yrs.
   IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William D.Hooper

14. MOTHER'S MAIDEN NAME: Florence Herty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dotes of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: William O.White

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Reticulum Cell Sarcoma of brain — INTERVAL BETWEEN ONSET AND DEATH: 3 months
   DUE TO
   (b): Lymphosarcoma Rt epitrochlear node — 3 yrs.
   DUE TO
   (c):
   Conditions, if any, which gove rise to immediote couse (a), stoting the underlying couse last.
   2000

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from _____, 1960, to 12-15, 1967, that (I) ~~(we)~~ last saw the deceased alive on 12-14 1967, and that death accurred at 8.55 AM, from causes and on the dote stated above

22a. SIGNATURE: Williford Eppes — M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 12-15-67

22c. PHYSICIAN'S NAME (Type): Williford Eppes

22d. ADDRESS: Newark, Delaware

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/18/67

23c. NAME OF CEMETERY OR CREMATORY: Head of Christiana

23d. LOCATION (City or Town) (County) (State): Newark, Delaware

24. FUNERAL DIRECTOR: R. T. Jones — ADDRESS: Newark, Del

25a. REC'D BY REGISTRAR DATE: DEC 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16864

CERTIFICATE OF DEATH

16858

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 34 days

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Alexandria
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria 83-3
d. STREET ADDRESS: 7965 Richmond Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital, Perry Point, Maryland

3. NAME OF DECEASED (Type or print): First: Allie — Middle: (NMI) — Last: Wilson

4. DATE OF DEATH: Month: December — Day: 7 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/26/14

9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Venetian blind worker

10b. KIND OF BUSINESS OR INDUSTRY: Manufacturing

11. BIRTHPLACE (County & State, or foreign country): Remington, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Wilson

14. MOTHER'S MAIDEN NAME: Carrie Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 229329994

17. INFORMANT: Hospital Records, VAH, Perry Point, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Insufficiency — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of Rectum with metastases to liver — 6 1/2 mos.
DUE TO
(c):

154 ✗

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/3/67, 19__, to 12/7/67, 19__ and that death occurred at 10:30 A.M., from causes and on the date stated above.
saw the deceased alive on 12/7/ 1967, and

22a. SIGNATURE: A. L. Mooney M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12-7-67

22c. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.

22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 12 Dec 67

23c. NAME OF CEMETERY OR CREMATORY: Culpepper Natl

23d. LOCATION (City or Town) (County) (State): Culpepper Virginia

24. FUNERAL DIRECTOR: Nile Dillon — ADDRESS: 814 Franklin St. Alexandria, Va.

25a. REC'D BY REGISTRAR DATE: DEC 11 1967

25b. REGISTRAR'S SIGNATURE: Edward Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16865

CERTIFICATE OF DEATH

16859

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): Union Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Md.
   b. COUNTY: Kent
   c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest tawn): Galena
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

14-2

3. **NAME OF DECEASED** (Type or print): First: RUTH — Middle: D. — Lost: WOOD

4. **DATE OF DEATH**: Month: December — Doy: 7, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June, 13, 1900

9. AGE (In years lost birthday) 67 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home.

11. BIRTHPLACE (County & Stote, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas H. Hollingsworth

14. MOTHER'S MAIDEN NAME: Elizabeth Dimirion

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.:

17. **INFORMANT**: Thos. Bryan Wood, — Address: Galena, Md. 21635

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: One hour

DUE TO

4201

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

(b) Arteriosclerotic Heart Disease — years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO OEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONOITION GIVEN IN PART I(o): Abscess Sphenoid with pharyngeal abscess, Alzheimer's Dis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this haspital) attended the deceased from Sept, 1959, to 7 Dec, 19 67 that (I) (we) last saw the deceased alive an 7 Dec 1967, and that death accurred at 8 P M, from causes and an the date stated abave.

22o. SIGNATURE: Wallace Obenshain — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 9 Dec 67

22c. PHYSICIAN'S NAME (Type): Wallace Obenshain. M.D.

22d. AOORESS: Cecilton, Md. 21913

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec.10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Galena Cemetery

23d. LOCATION (City or Town) Galena, (County) Kent (Stote) Md.

24. FUNERAL DIRECTOR: Edward Fellows & Son, — ADDRESS: Millington, Md. 21651

25o. REC'D BY REGISTRAR DATE: DEC 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16866

CERTIFICATE OF DEATH

16860

1. **PLACE OF DEATH**
   a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   d. STREET ADDRESS: 115 Bellas Lane
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: George — Middle: — Last: Wright

4. **DATE OF DEATH**: Month: Dec. — Day: 8 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

8. DATE OF BIRTH: June 15,1903

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Wright

14. MOTHER'S MAIDEN NAME: Mary Starling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 213-18-6038

17. **INFORMANT**: George Wright, Jr. — Address: 48 S. Locust St. Smyrna, Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 months
   DUE TO (b):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
   331X

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct. 29, 1967, to Dec. 8, 1967, that (I) (we) last saw the deceased alive on Dec. 7 1967, and that death occurred at 6:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: S. Ralph Andrews, Jr. M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: Dec. 8, 1967

22c. PHYSICIAN'S NAME (Type): S. RALPH ANDREWS, JR. M.D.

22d. ADDRESS: 223 E. Main St., Elkton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/13/67

23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cem.

23d. LOCATION (City or Town) (County) (State): Bohemia Manor, Md.

24. FUNERAL DIRECTOR: Edwin C. Bell — ADDRESS: 909 Poplar St.

25a. REC'D BY REGISTRAR DATE: DEC 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16867

CERTIFICATE OF DEATH

16861

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Pa. MD — b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nottingham, Pa. R.D.1 — c. LENGTH OF STAY IN 1b: life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nottingham, Pa. R.D. 1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
James	Vincent	Yale, Sr.	Dec.	1	67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	WIDOWED [X]	Oct. 28, '86	81 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Own Farm	North Carolina	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Valet Yale, Jr.	Millie Spicer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor ar dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	190-16-7721	James Yale Nottingham, R.D.. 1, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebrovascular accident	8 days
DUE TO (b)	Cerebral arteriosclerosis	10 years
DUE TO (c)	Diabetes mellitus	10 years

Conditians, if any, which gave rise to immediate couse (a), stoting the underlying couse last.

260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture af injury in Port I ar Part II of item 18.)		
20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at wark [ ] Not While at wark [ ]	20e. PLACE OF INJURY (Home, form, factory, street, affice bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 10-15, 1967, to 12-1, 1967, that (I) (we) last saw the deceased alive an 11-30, 1967, and that death accurred at 3.30 PM, from causes and an the date stated abave.

22a. SIGNATURE	M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22b. DATE SIGNED
Neil R. Taylor, Jr.		12-4-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Neil R. Taylor, Jr.	Rising Sun, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Dec. 4, '67	Friends Cemetery	Calvert Cecil Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Vernon B. McMullen	Rising Sun, Md	DEC 5 1967	J. Charles Judge

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4/18/68